

www.marylandcancerplan.org
Colorectal Cancer Committee Meeting #1
May 1, 2002, 4-6pm
201 W. Preston St, Rm L-2
MINUTES

⇒ **Introductions and Committee Membership (Kate Shockley)**

- DHMH staff and committee members were introduced by name and organization.
- A committee roster was passed around. Members were asked to make corrections and add credentials and job titles.
- Member information, including name and organization, will be listed on the website and in the final published cancer plan. Members were given an opportunity to raise objections or ask questions. No members objected to this display of their information.

⇒ **Background on Comprehensive Cancer Control (Robert Villanueva)**

- Comprehensive cancer control is the development of an integrated and coordinated approach to reduce the incidence, morbidity, and mortality of cancer through prevention, early detection, treatment, rehabilitation, and palliation.
- In June 2001, an RFA was released by the CDC and states were encouraged to apply for funds to either write or implement a Comprehensive Cancer Control plan in their state. Maryland applied for funds to update the existing cancer plan.
- In September of 2001, the Maryland DHMH was awarded a 2-year cooperative agreement to update the 1996 Maryland Cancer Plan.
- Currently there are 13 states funded to implement their Comprehensive Cancer Control plans. In addition, there are 7 states funded under the Planning phase and scheduled to update or rewrite their cancer plans.
- Many states have existing cancer plans, and the colorectal cancer sections of the Michigan and Massachusetts plans can be found in the Committee Materials binder.
- The American Cancer Society, CDC, and NCI continue to monitor the progress of states moving towards developing Comprehensive Cancer Control plans.

⇒ **Organizational Structure and Evaluation Component (Bowie Little-Downs)**

- The Maryland Council on Cancer Control and key administrators within the DHMH/ Center for Surveillance and Cancer Control are charged with the oversight for this grant. An organizational chart for the planning process is included in the Committee Materials binder.
- To date, the Core Planning Team has been responsible for the planning and preparation that took place over the first 6-8 months. This team has now transitioned so that it will provide overall monitoring and guidance to all committees and sub-committees.
- From within this Core Planning Team there are 6 individuals that make up the Evaluation Committee. It is the responsibility of the Evaluation Committee to help guide the process by which each Sub-Committee operates.
- The Evaluation Committee selected the CIPP Evaluation Model when writing the grant proposal. CIPP is an acronym for Content, Intput, Process and Product. The CIPP Model is a process/satisfaction-oriented evaluation tool designed to evolve as we move through the various phases of developing a new cancer plan for Maryland.
- At the end of each meeting, committee members will be asked to complete a one-page evaluation and turn it in to the staff liaison attending your session. The comments will be compiled and shared with you at the beginning of each subsequent meeting. Changes will be made in the meeting process as may be warranted based on the group comments. (i.e.: the Core Planning Team incorporated the use of name tags after their first meeting).

- The evaluation form is also available online for those not able to complete it at the end of the meeting (<http://www.marylandcancerplan.org/evaluation.html>).

⇒**Background on past Maryland Cancer Plans (Kate Shockley)**

- The 1991 Maryland Cancer Plan did not include a section on colorectal cancer. The plan was then updated in 1996 to include sections on colorectal cancer and prostate cancer. The colorectal cancer section of the 1996 plan can be found in the Committee Materials binder.
- The 2003 cancer plan will be updated and expanded even further to include sections on oral cancer and skin cancer, as well as sections dealing with palliative care. A draft Table of Contents for the 2003 plan is included in the Committee Materials binder.
- The task of each of the committees is to develop a focus on racial and ethnic disparities and then to formulate recommendations pertaining to the control of colorectal cancer and the reduction of these disparities.

⇒**Establishment of Next Meeting Dates (Kate Shockley)**

- The committee was presented with several options for next meeting dates.
- Members voted to move the meetings an hour earlier, to the 3-5pm time slot.
- The next meetings of the committee will be:
 - May 22, 2002, 3-5pm
 - May 29, 2002, 3-5pm

⇒**Presentation of Data (Diane Dwyer)**

- Slides available in the Committee Materials binder.
- Description of breakdown of Maryland population into general population, people with polyps, people with colorectal cancer (CRC), and people who die from CRC.
- Description of various sources of data, types of studies and how these help us understand the disease and possibly prevention of the disease.
- Breakdown of types of recommendations that can be made. These categories are Primary Prevention (behavior change), Secondary Prevention (screening), and Treatment.
- Committee members completed a brief survey regarding objectives for decreasing the burden of CRC in Maryland and decreasing racial disparities.
- Dr. Dwyer reviewed the data for incidence, mortality, and behavioral factors pertaining to CRC. Summary points include the following:

- Maryland exceeds the US in incidence and mortality for CRC
- Blacks in Maryland have higher rates of CRC incidence and mortality than whites
- Men have higher rates than women
- CRC incidence and mortality varies by region of MD
- More Maryland cases are unstaged than in the US (SEER)
- More whites are diagnosed at local or regional stage than are blacks; fewer are unstaged
- The percent of adults who have had an FOBT increased between 1997 and 1999
- The number of adults who said they have ever had a sigmoidoscopy or colonoscopy was 50.4% in 1999

- Summary of key points and questions throughout the discussion of the data:
 - Rates increased in 1996 in black males in Maryland- can we attempt to explain this?
 - In general, knowledge of risk factors and access to screening is much lower in poor black regions (such as studies of knowledge done in Harlem, NY)
 - We may want to address other methods of surveying populations that may not typically have telephone access
 - Rates in the national Capitol area are lower than the US, which may warrant investigation

- Montgomery and Queen Anne's counties have statistically significant lower rates than the US, which may warrant investigation
- Dr. Kern suggests a comparison of stage at diagnosis to the screening method
- Suggestion to investigate screening method by race
- Overall, whites are diagnosed at earlier stage of disease
- Questions about insurance coverage in various regions of Maryland (some information may be available from the Task Force data)
- Questions regarding the BRFSS data, and whether the screening questions should address whether the test was done symptomatically or asymptotically
- Questions regarding getting hospitals to better report stage of disease
- Suggestion to address the barriers that various screening methods inherently impose
- Suggestion to involve role models to clearly explain the risks and benefits of screening and use sensitivity when phrasing the message
- Suggestion to really focus on the high incidence among African-American and men of African descent, especially looking at regional differences
- Members offered to share information regarding the results of focus groups on CRC screening at the next meeting.
- The next meeting will also address literature review and interventions. The following meeting will address programs and policies pertaining to CRC which are in place already.
- Members completed their survey and evaluation form.

⇒**Transcription of flip chart**

Additional questions/data needed:

- Did the prostate cancer incidence rate increase as with CRC around 1996, implying more screening?
- Treatment Task Force Insurance data- insurance rates by region
- Gender, age, and race data presented together for incidence and mortality